Gail Klayman Honored with 2012 Mary Barkey Clinical Excellence Award

At the Opening General Session of the 30th Annual Conference in Washington, DC, the Child Life Council presented the third annual Mary Barkey Clinical Excellence Award to Gail Klayman, MEd, CCLS, Adaptive Care Team Coordinator at Cincinnati Children’s Hospital Medical Center in Ohio. The Child Life Council established the Clinical Excellence Award to recognize child life specialists who have demonstrated exemplary child life care and a high level of clinical skill.

The CLC Board of Directors named Gail as the recipient of the 2012 award in recognition of her long history of innovation and leadership in the clinical setting. Among many other accomplishments over her 40-year career, Gail was recognized for her pioneering work in the Pediatric Intensive Care Unit, Neonatal Intensive Care Unit, Starshine Hospice, and the Division of Developmental and Behavioral Pediatrics at Cincinnati Children's Hospital Medical Center (CCHMC). In 2009, she initiated the Adaptive Care Team, which provides preparation and support to patients with developmental and behavioral challenges. Over the past two years, Gail has partnered with a colleague at CCHMC in the development and evaluation of an assessment tool called the Psychosocial Risk Assessment in Pediatrics (PRAP), which they hope to share with child life programs throughout North America.

“This is the highlight of my career since it is the most prestigious clinical award in the profession,” Gail says of her selection for the award.

The ten criteria developed for the Mary Barkey Clinical Excellence Award focus on key areas for the provision of quality psychosocial care. With the permission of her colleagues who submitted Gail’s name for consideration for the award, we are pleased to share excerpts from her nomination materials as evidence of just a few of the ways that Gail Klayman has exemplified clinical excellence in child life.
Looking Back as We Look Forward

Toni Miller, MS, CCLS, 2011-2012 CLC President

As I ended my term as Child Life Council (CLC) President, I was proud to look back on a full and productive year for CLC. I was acutely aware of how CLC continues to learn from its history as it continues to be future-focused. Modifications to methodologies and practice help to stave off stagnation as well as promote the ability to align with current trends. In my final column, I would like to discuss some key examples of this pattern regarding evolving CLC practices and to imagine what CLC may look like in the year 2020 as a result of our professional vision.

I have often remarked on the consistent quality of CLC conference presentations, and this past 2012 CLC Conference in Washington, DC, was no exception! It was an amazing conference, and the cornucopia of topics we had to choose from was dazzling. It reinforced to me how our membership has always been creative and proactive in providing psychosocial services to pediatric patients and their families. Now, this creativity is supported by evidence-based practice and research, and our members are willing to share these innovations freely with their colleagues.

Historically, members have shared their knowledge in the spirit of collaboration, with the goal of improving the experiences of children and families everywhere. Going forward, this type of professional generosity will ensure that child life specialists are providing consistent, advanced, professional services.

With the formation of the Leadership Development Committee, CLC began to explore and develop a variety of mentoring and educational initiatives to enhance the leadership skills of both new and established child life leaders.

As a professional association led primarily by elected volunteer leaders, CLC realized that it was critical to provide training and development opportunities to ensure our members maximize their talents in guiding the organization. With the formation of the Leadership Development Committee, CLC began to explore and develop a variety of mentoring and educational initiatives to enhance the leadership skills of both new and established child life leaders. Several of these initiatives are already underway, including a Child Life Mentor Pilot Program, which was introduced by the committee earlier this year.

In addition to providing new leadership development opportunities for the general membership, CLC has also made changes to the way we conduct the transition from one Board term to the next. In the past, newly elected CLC Board members were welcomed into Board discussions only after the Annual Conference, and they were expected to jump into projects/committees already in progress without a familiarization period. This resulted in confusion, communication mishaps and delays in progress of ongoing initiatives. Learning from these experiences, CLC has now established the practice that all newly-elected Board members will attend the full Board meeting prior to the Annual Conference. In addition to this Board “practicum” experience for incoming CLC Board members, a facilitator will conduct a seminar on how to be an effective board member and volunteer leader.

Leadership development for the CLC President’s role has also improved over the past few years. Each spring, the CLC Executive Director, President and President-Elect introduced by the committee earlier this year.

Leadership development for the CLC President’s role has also improved over the past few years. Each spring, the CLC Executive Director, President and President-Elect...
As I take a new path in my career and begin my role as Executive Editor of *Focus*, I find myself reflecting on the events that brought me to this place and, more importantly, the people I have encountered along the way. In the ten years since I entered the field of child life, I have benefited from the mentorship of exceptional clinicians, groundbreaking leaders, and gifted researchers. The lessons I’ve learned from them have changed me both professionally and personally. Thinking about the way these tenured child life specialists have inspired my career course made me think about the impact of mentorship within our profession.

By its most basic definition, mentorship is the product of a professional relationship in which a seasoned person helps to guide the career development of a less seasoned person. In practice, mentorship is much more than this definition, being rather a rich experience that hinges on communication, mutual respect and hard work. A true mentorship is an ongoing relationship steeped in learning, dialog, and career challenges that goes far beyond simply answering the occasional question or offering intermittent professional advice.

Being a mentor is an active choice, something to which a person consciously makes a commitment. Being a strong and effective mentor is a responsibility that requires, among other things, time and energy. The child life specialists who invested their time and energy in me throughout the years were often pulled in many directions, leaving them short on both of these key ingredients. Their choice to prioritize our relationship helped to propel me forward by providing scaffolding to my professional development in much the same way our clinical interventions scaffold a patient’s ability to cope with their hospital experience. They walked me through the process, helped me to identify my strengths and develop my weaknesses, and taught me how to grow from my struggles.

Engaging in the mentorship relationship is also a choice on the part of the mentee. He or she must possess the desire to grow and be willing to trust in the value of being mentored. As a mentee there were times when I was impatient, like a child wanting to grow up too soon, sidestepping milestones that are gained through experience. In these moments, my mentors offered support and guidance, encouraging me to recognize the valuable lessons that I was learning in the present and showing me how these lessons would serve me in the future. As a mentee I also had to be comfortable examining my practice not only from my own perspective but also through that of my mentors, an exercise that taught me how to see myself as part of the healthcare team.

As a mentor you may not always have the opportunity to witness the results of the investment you have made in your mentee, but it remains a worthwhile endeavor as the years pass on and the mentee matures to become a mentor herself. I challenge you this fall to enhance your professional development by choosing to participate in a mentorship relationship, because we can all benefit from the wisdom of those who came before us.

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**Personal Journeys and New Beginnings**

*Jaime Bruce Holliman, MA, CCLS*

*In every art beginners must start with models of those who have practiced the same art before them.*

—*Ruth Whitman (1922-1999)*

*Poet, professor and mentor*

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**Milestones**

**Retirement**

Virginia “Ginny” Finn, MSED, CCLS, Director of the Child Life Program at the Floating Hospital in Boston, is retiring August 30, 2012, after 44 years of service.

Luci Weber, CCLS, Director of the Child Life Department at All Children’s Hospital in St. Petersburg, Florida, officially retired on June 1, 2012 after 31 years of service.

**Promoted**

Kristin Maier, CCLS, was appointed Director of the Child Life Department at All Children’s Hospital in St. Petersburg, Florida; she was mentored by Luci Weber for most of the past 25 years. Kristin has worked as a specialist and as the Clinical Coordinator for the All Children’s Hospital Child Life Department.

**Published**

Cara Sisk, MA, CCLS, Tennessee Tech University; Elizabeth Walker, MEd; Clare Gardner, BS, CCLS, St. Jude Children’s Research Hospital; Belinda Mandrell, PhD, RN; and Shawna Grissom, MS, CCLS, CEIM, St. Jude Children’s Research Hospital, published their article, “Building a Legacy for Children and Adolescents With Chronic Disease,” in the May 2012 issue of the *Journal of Pediatric Nursing.*

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Looking Back, Looking Forward

Reflecting on the history of the child life profession prompts us all to reflect on our own personal and professional histories. Just as the founders of child life set into motion a profession built on mentorship and support, so too does each generation of child life professionals pass on these same qualities to his or her colleagues, interns, and students. However, we cannot hope to clearly chart the course of our future without paying tribute to those supervisors and colleagues who have made us who we are today. In this issue’s anniversary column, our guest authors describe their first child life positions and reflect upon the knowledge and experience gained. As you read, we invite you all to consider your own child life history and the many lessons you may have learned along the way.

Redefining Success: My First Child Life Position

Desiree Heide, CCLS, St. Jude Children’s Research Hospital, Memphis, TN

My practicum? Done. Internship? Completed. Child life certification, job offer, and new apartment in a new city? Check, check, and check! Life was finally falling into place. I changed into my issued brown scrubs and monogrammed blue polo shirt, tucked my file boxes stuffed with pill-swallowing tips and coping techniques under my arms, and with trembling legs stepped through the doors of Dell Children’s Medical Center in Austin, TX, for my first day of work as a certified child life specialist. I had made it!

I was assigned to a 24-bed surgical/trauma unit, and the first few weeks in my position were a whirlwind of meeting new faces, poring over policies and protocols, and feeling overwhelmed with the responsibilities – yet thrilled at the possibilities – that lay ahead. I woke up each morning excited to go to work, positive I was going to change the lives of the patients I worked with, if not the world! I jumped in head first, providing education and therapeutic activities: blowing through gallons of bubbles in the procedure rooms, facilitating impromptu medical play sessions, and helping patients turn frustrations into laughter as we threw toilet paper “spit wads” at lists of things they hated about the hospital.

I loved what I was doing, and while I felt myself growing professionally and gaining confidence during those first months and years, there was one truth I just couldn’t seem to fully embrace: the fact that I didn’t have to know all the answers, or provide the perfect therapeutic intervention to be a successful child life specialist.

I’ll never forget one particular experience with a 5 year-old patient that finally drove that truth home to me: ten inches of her thick, dark hair had recently been shaved for a necessary surgery. Her illness had caused nerve damage to her face, affecting her ability to swallow, and the scans and treatments she had previously undergone with ease were now causing her paralyzing fear and anxiety. Her mother had come to me desperate for ideas to help her daughter cope, so I met with the 5-year-old in a one-on-one session in the playroom, where I pulled out every intervention and coping technique I had ever learned to try to break through to her. My inexperience and feelings of inadequacy screamed at me as she sat next to me in almost complete silence, her countenance flat and unchanged.

As my shift and our session drew to a close, I remember vividly the feelings of helplessness, frustration, and failure that shrouded me. I was returning to her mother the same scared little girl who had walked in the room with me an hour before. I had done nothing to help. I pushed her IV pole towards the playroom door with a heavy heart, and as I fumbled for my keys, my glitter wand fell out of the back pocket of my scrubs. When I reached down to retrieve it, the bright pink glitter inside shook to life, and my 5 year-old patient asked, “What is that?”

Surprised by her fascination, I knelt in front of her and held the wand up for her to see, flipping it over and over and causing the glitter to swirl and shimmer. She stared, mesmerized by the wand, and for the first time that evening a smile emerged on her lips. I could scarcely believe it!

An hour of implementing every intervention and coping strategy known to man, and it was the magic of a simple glitter wand that had broken through to her. She reached for the wand with one hand and for my hand with her other, and together we headed back towards her room and waiting mother, the smile still on her face and the sparkle of fascination still in her eyes. I might not have changed the world that night, but as we walked down the hall the words often attributed to Ralph Waldo Emerson echoed in my mind: “To know that even one life has breathed easier because [I] have lived. This is to have succeeded.”
Discovering Success Throughout a Career
Belinda “Bindy” Sweett, CCLS, Sooke, BC, Canada

Attending university was a privilege for me. I had wished for it for years, but opportunity waited. After a career in early childhood education, and as a new graduate with a B.A. in Child Care at 38, I came to the child life specialty later than most. I had worked with children aged 18 months to five years and coordinated an out of school program while attending university, but I had never worked with youth. My expertise was in early childhood development and programming, and I really only knew child life through experience as a parent and my coursework.

My internship, called a practicum at that time, took place in 1987/88. I worked two days a week for two semesters, something very different than the block placements offered today. In a general hospital pediatric unit, developing long-term relationships was challenging, with most patients admitted for general diagnoses. I took the opportunities I could to work with older patients to gain that experience, but there were few. Most of our “frequent patients” had established relationships with child life staff, and seemed to cope well with their admissions. I learned about their stays from a distance, and cannot remember any specific experiences of self-discovery in those situations.

However, one particular 16 year-old holds a place in my memory. She had lupus, and as a result, was often in pain. The many issues surrounding pain were important to me after living through the death of my daughter, and I was willing to take chances to help this girl. One of the established relationships was my part in delivering them. Since then, a huge shift occurred in my practice. I think that particular experience, in the longer run, taught me to reflect more on the process, and less on the plan, though planning is important in retrospect, was that she and I developed a therapeutic relationship. In the moment, awareness of the power of this phenomenon had been almost absent. It was probably my first relationship with a hospitalized youth, and I was spending all my energy on developing strategies, and my part in delivering them. Since then, I was full of hope, ideas and ideals, and it was exhilarating to hold them within me.

This was my first attempt at using imagery, and I knew so little about what I was doing. I remember that we found it easy to talk together, and that her parents supported and encouraged her trust in me. In retrospect, I realize now that I thought that her pain control was all about me! My idea, my tape, my voice, my images -- it took a while for me to understand what “using the patient’s strengths and interests” really meant. Yes, she was willing to work with me, and I was eager to try out my beginner repertoire of interventions. It was a very short list indeed, and I had no experience or real training at all. I was trying something I had read about in my textbooks!

I was amazed and immensely satisfied when she responded so well to the strategy, and “chalked one up” as a successful outcome. I figured I had one in my pocket. But was that particular intervention the real success within the context of this patient, her illness, her family, the pediatric unit, my practicum, my values and my learning? I see it so differently now. The successes look different, and who owns them does too.

What was less appreciated at the time, and most important in retrospect, was that she and I developed a therapeutic relationship. In the moment, awareness of the power of this phenomenon had been almost absent. It was probably my first relationship with a hospitalized youth, and I was spending all my energy on developing strategies, and my part in delivering them. Since then, a huge shift occurred in my practice. I think that particular experience, in the longer run, taught me to reflect more on the process, and less on the plan, though planning is not unimportant. Over time, I learned not to obsess or fuss about failed interventions. We try what we know, or in my case, what I thought I knew. What I thought I knew did not include much that this particular patient, which now makes me cringe. It is not without embarrassment that I share my dumb pride. If one approach seems to fail, I have learned to move on. If something else works, it is because of the patient’s part in it, not mine. The challenges, after all, are theirs, not ours.

Greater satisfaction has come from the feeling of connection to others, and the shared power that is present within that relationship. I feel more gratification in observing intrinsic problem solving. I realize why this has been so important for me to instill in interns, to question what did work, why it worked, and what it is that we don’t know about this patient. How is it that a child finds the strength to help him or herself? I hope all interns learn to think about different ways to approach the “case.” There must have been so much that I did not know about my early patient with lupus and her family. There was certainly a good deal about myself of which I was unaware. I eventually learned to approach the child or youth without an agenda, to keep an open mind. My greatest desire became to learn about others, to understand them, to get into their skins.

It is so much less important to me now to be visible within the relationship. I prefer to act in the background, to serve as a sounding board or an absorber of pain, rather than as a giver of information and a provider of help or solutions. It took a while to know how to ask, “Have you ever thought about this? Or what do you think will help?”

Instead of suggesting that I have a solution to another’s problem, I grasp that real success depends on the patient’s ideas, her “tape,” her voice, her images. Once I know who she is, I can be a facilitator, but the patient is the one who does the work, accumulates the accomplishments, deserves the praise, and should be the possessor of pride.

It was my good fortune to have met this young woman and her family, and had the chance to learn from her. Like all students, I was full of hope, ideas and ideals, and it was exhilarating to hold themselves within me. I was out to change the world, and like my colleagues, I have seen the world changing. We all play a part in change. Many of my ideals have remained constant, but the road to reaching them is not as direct as it once seemed to be.

There are more hills, dead ends and curves along the way, and there is a cast of characters and a litany of incidents that contributed to altered directions. I realize that though the road has been longer, more challenging, and more unclear than I anticipated, it has been paved with incredible opportunities, and I had better pay attention rather than miss them.
Evidence-based practice is a term that is heard more and more within health care, and one that health care clinicians are encouraged to embrace and integrate in order to ensure the best outcomes for children and families. Cincinnati Children’s Hospital Medical Center (CCHMC) values this philosophy and has developed a program to help the everyday clinician have a more hands-on encounter with evidence-based practice (EBP). This program is called the Point of Care (POC) Scholar program.

Many child life specialists who work at the bedside spend the majority of their time with patients and families. It can be difficult to get away for meetings and even more challenging to find time to tackle an EBP project. As child life staff, we are often aware of clinical and psychosocial issues relevant to patients and families; however, we may feel that we do not have the time, resources, or knowledge to undertake a research project.

The Point of Care Scholar program exists to provide clinicians who work regularly with patients and families the opportunity to spend time investigating a research question that is relevant to their clinical practice. Mary Ellen Meier, POC Scholar and EBP mentor, shared that the purpose of the POC Scholar program is “to promote the use of evidence and research by nurses, advanced practice nurses, and allied health professionals to improve patient, family, and staff outcomes” (personal communication, March 30, 2012).

As a part of this program, CCHMC provides funds for the POC Scholar to spend one day a week over a one year period to work on an evidence-based project while another clinician covers the Scholar’s clinical responsibilities.

During the year, the POC Scholar receives training and education in EBP, research, and quality improvement. Various speakers present lectures on topics such as conducting a literature search, developing a PICO(T) (population, intervention, comparison, outcome, and time) question, appraising the strength of literature, making a recommendation, implementing a practice change, submitting to an institutional review board (IRB), disseminating findings, etc. Scholars are provided with time and support to work on an EBP project and evaluate practice changes that are made as a result of the evidence.

Each Scholar works throughout the year on answering a PICO(T) question related to their field and area of expertise. Each is assigned an EBP mentor who provides ongoing support and feedback throughout the year. This mentor helps the Scholar identify evidence to support or change current practice in their clinical arena, set up a team of subject matter experts, and evaluate how the evidence-based practice impacts patient, family, and staff outcomes.

As part of the POC Scholar year, the Scholar is expected to:

- formulate a specific clinical practice question,
- search and critically appraise literature,
- synthesize findings,
- test findings through performance improvement and/or research,
- evaluate outcomes
- develop and publish a best evidence statement of practice on the hospital’s internal and external websites (Cincinnati Children’s Hospital Medical Center, 2012),
- disseminate findings to the department, hospital, and beyond, and
- present POC work in a variety of settings, including Interdisciplinary Grand Rounds.

After completing the program, Scholars are expected to distribute and integrate findings into practice and to disseminate POC Scholar work outside CCHMC through professional presentations, publications, or posters. Within CCHMC, graduated Scholars serve on a Shared Governance Council as a full or ad hoc member in order to guide others in the work of evidence-based practice. Additionally, Scholars lead another EBP project within 2 years post-graduation and serve as a resource to subject matter experts who review, revise, or retire nursing practice, interdisciplinary or clinical policies, procedures or guidelines, and they are a resource to RN Residents and staff.

To date, the Child Life and Integrative Care department of Cincinnati Children’s has supported four child life specialists, one music therapist, and two holistic health specialists in the POC Scholar program. Each of these clinicians has joined Scholars from other disciplines in tackling clinical questions that have potential to greatly influence clinical practice here at Cincinnati Children’s and beyond. Clinical issues investigated by the Child Life and Integrative Care staff include: medical play preparation in children with history of abuse or neglect, craniosacral therapy in children with autism and/or sensory processing disorder, effectiveness of child life during procedures, massage therapy for patients with cystic fibrosis, sibling support in end of life care, and the

continued on page 7
Compassion Fatigue, Burnout and Clinical Supervision for the Child Life Specialist

Margaret Kay Brinson, MS, Bank Street College of Education, New York, NY

Abstract

A child life specialist's role is to provide psychosocial care to children and families through challenging medical situations. Statistics show growing reports of burnout and compassion fatigue in many healthcare professions, a risk which is likely also present for child life specialists (Carabello, McCabe & Gionfriddo, 2003). To prevent against burnout, supervision has been defined as a positive form of professional support in professions such as social work, nursing and even child life. However, there is little research specifically regarding burnout or compassion fatigue for child life specialists or the impact that supervision may have for this population. In this study, two surveys were distributed to child life specialists both at a regional conference in the Northeastern United States and a subset of hospitals in the Southern United States. The two surveys included the Professional Quality of Life Scale (Stamm, 1995) regarding compassion fatigue and burnout and an additional supervision survey constructed by study staff that asked participants about their perceptions and experience with supervision in their work environment. Results showed that more than fifty percent of participants were at high risk for compassion fatigue and burnout despite receiving consistent supervision. A reconsideration of supervision for child life specialists is needed to better meet the emotional needs of this population.

As the delivery of healthcare changes, more importance is being placed on patient feedback and satisfaction regarding the healthcare experience. Child life specialists are one particular group of healthcare employees who are tasked with providing optimal psychosocial care to patients that are hospitalized. In addition to hospitalization, these patients may also experience traumatic and challenging situations such as abuse, homicide and chronic illness. These complex cases are further complicated by the numerous changes taking place in the healthcare system. A struggling economy, stricter budgets, and major reforms are putting more pressure on employees to work diligently, collaboratively and effectively with fewer resources and support. More and more employees are finding that they are working harder, yet doing less to take care of themselves physically, mentally and emotionally (Carabello, McCabe & Gionfriddo, 2003).

Statistics show that certain stressors in the healthcare system are becoming more of a reality. There has been a significant rise in employees experiencing compassion fatigue and burnout (Carabello, McCabe & Gionfriddo 2003; Tehrani, 2007). According to a study by Carabello et al. (2003), 80% of first responders and crisis workers, along with 60-70% of mental healthcare providers, report experiencing compassion fatigue, which is defined as the stress resulting from helping or wanting to help another traumatized person. Compassion fatigue refers to a physical, emotional and spiritual fatigue or exhaustion that takes over a person and causes decline in his/her ability to experience joy or to feel and care for others (Figley, 2002).

Compassion fatigue is also synonymous with the terms secondary traumatic stress syndrome and vicarious trauma (Figley, 2002). In a study of 430 social workers, 60% described strong negative beliefs contributing to burn out such as feeling overwhelmed or believing they should have coped more effectively (Tehrani, 2007). Burn out is defined as an unrelieved form of stress that results in a psychological condition of negativity towards one’s work environment and has principal components which include emotional exhaustion, maladaptive detachment and cynicism (Bartell, 2012). Sixty-four percent of social workers experienced a shift in worldview when working through traumatic events, coming to believe in the world as a dangerous place overall (Tehrani, 2007). These statistics suggest that a high percentage of those healthcare workers are at risk of or are currently experiencing symptoms of compassion fatigue and burnout.

Literature Review

A review of the literature suggests that there is little to no research, however, on the prevalence of burn out and compassion fatigue among child life specialists. Many child life specialists would agree that a child life specialist’s ability to compassionately care for others can also become a great weakness if not monitored carefully (Skovholt, 2001). While child life specialists have a unique role in supporting families and staff in a medical environment, this role can also render them susceptible to the hazards of work related stress. The purpose of this study was to examine rates of compassion fatigue and burnout in continued on Focus page 2
child life specialists, and to investigate any possible relationships between these rates and the level of professional supervision support available to these employees.

The research cited above suggests that compassion fatigue and burnout are common among healthcare professionals; some researchers describe compassion fatigue and burnout as “a diagnosis waiting to happen” (Figley, 2002, p. 20; Skokvolt, 2001). In acknowledging these increasingly common and difficult conditions, it is essential to assess the factors that contribute to the development of compassion fatigue and burnout and to develop programs toward prevention and treatment. As child life specialists are at risk for this phenomenon, programs and interventions need to be developed to directly address the unique needs and concerns of this population. This study therefore sought to assess the incidence of compassion fatigue and burnout in practicing child life specialists.

In other related healthcare fields, importance has been placed on the availability of professional support systems to address compassion fatigue and burnout. According to Tehrani (2007), 92% of health care professionals reported positive feelings toward their work environment when they had greater access to support systems, with the most important support system being friends and colleagues (77%), followed by family (62%) and professional support (57%). These findings suggest that clinical supervision within the work environment can be helpful to healthcare professionals.

The field of child life has recognized the importance of establishing standards and guidelines for child life supervision. In 2008, The Child Life Council executive board approved a clinical supervision position statement, which suggested that child life specialists face daily and complex clinical situations that, if not addressed in a proper manner, may jeopardize their sense of competency or wellbeing. This position statement proposed specific guidelines and formats for creating a supportive clinical supervision program that addresses issues surrounding compassion fatigue and burnout (Brown, Mattera, Miller, Palm & Rode, 2008). A leader in establishing child life clinical supervision, Gloria Mattera, stated that the ‘essence’ of child life clinical supervision is the reflective process (personal communication March 11, 2012). By encouraging practitioners to think critically and reflectively on their professional skills with a supervisor or colleague, a child life practitioner gains therapeutic competence, critical thinking skills and reflective skills which are necessary in healthy professional development and combating compassion fatigue and burnout (Bartell, 2012; Brown et. al, 2008; Tehrani, 2007).

When the Child Life Council’s clinical supervision task force developed the protocols that should be in place for child life clinical supervision, they also provided a map adapted from Hawkins and Shohet (2000) that would help guide effective supervision conceptualization and implementation (Rode, 2005). To date, though, the current literature has not yet evaluated the effectiveness or implementation of child life clinical supervision and how it may relate to compassion fatigue and burnout.

The present study is a pioneer attempt to research specifically the prevalence of both compassion fatigue and burnout in the child life practice as well as the prevalence and effectiveness of child life supervision. Specifically, this study asked the questions: are child life specialists at risk for compassion fatigue and burnout? From the current literature, we expected that this study would reveal the majority of child life specialists to be at high risk for compassion fatigue and burnout. We also expected that clinical supervision would reduce compassion fatigue and burnout. Therefore, the present study speculates that participants who report consistent and quality supervision will show to be at minimal risk for developing compassion fatigue and burnout.

**METHODS**

Forty-four child life specialists participated in this study. A majority of the participants were recruited while attending a local child life conference in the Northeastern United States. These participants were given two surveys to complete and turn in while attending the conference. For easy distribution, the research surveys were placed in the welcome packets given to each child life specialist who attended the conference. Instructions were given at the conference on how to complete the survey and how to collect incentive gift cards.
Other participants included fourteen child life specialists from one regional medical center in the Southern United States who were recruited as a convenience sample. These participants were sent both surveys by standard mail. The packaging sent to these participants included a pre-paid return address so that completing the surveys would be as easy as possible. All subjects were aware that the information they provided would be used for research purposes and would not be connected to their identifying information.

**MEASURES**

**Professional Quality of Life Scale or ProQOL** (Stamm, 2005) (See Appendix A). The ProQOL is an internationally reliable 30 question survey which aims to rate a professional's risk for compassion satisfaction, burnout, and compassion fatigue by asking 30 questions involving one's personal feelings and emotions surrounding their work environment. People would rate questions based on a one to five scale (One being ‘Never’ and Five being ‘Very Often’). This survey was accessed from the professional quality of life website (ProQOL.org) and can be freely used for research purposes so long as it is appropriately cited. Due to a limited amount of researchers conducting calculations of the two surveys, the ProQOL 5 Self Score was used to obtain simple and accurate data, which can also be found on ProQOL.org website.

**Supervision Survey** (See Appendix B). This researcher-constructed survey was designed to assess participants’ history of clinical supervision, perceived quality of supervision, as well as the consistency of supervision received. This survey was formulated by the researchers of this study and has not been validated or used elsewhere. The Supervision Survey asked questions about the consistency of supervision participants receive in their work environment as well as their personal perception of the quality of supervision they are receiving. Participants answered this survey using a rating scale. An optional open-ended question at the end of the Supervision Survey asked participants to write a brief description of their personal definition of supervision involving their own experience as a child life specialist.

**RESULTS**

Out of the 44 child life specialists who completed the ProQOL survey, 33 (75%) received a score of 57 or higher suggesting they were at risk for either compassion fatigue or burnout. Twenty-one participants (47%) were at risk for compassion fatigue, while twelve (27%) reported being at risk for burnout. Five child life specialists (11%) were found to be at risk for both compassion fatigue and burnout (see Figure 1).

The findings from the supervision survey suggest that child life supervision is being carried out consistently, and yet risk for compassion fatigue and burnout remain high among child life specialists.

Out of 44 child life specialists who completed the Supervision Survey, 16 (36%) reported that they received supervision in their work environments “Somewhat Often”. Fifteen child life specialists (34%) reported receiving supervision in their work environment “Very Often”. Only three child life specialists (6%) reported to “Never” receive supervision in their work environment, and six child life specialists (14%) responded with “I Am Not Sure” when asked if they receive supervision in their work environment (see Figure 2).

An important, unexpected finding showed that the two participants who reported themselves at highest risk for both compassion fatigue and burnout also identified themselves as one-person programs in the additional comment section of the Supervision Survey.

**DISCUSSION**

The results of this study seem to raise new questions regarding both the type and quality of supervision being given. The findings from the supervision survey suggest that child life supervision is being carried out consistently, and yet risk for compassion fatigue and burnout remain high among child life specialists. Though past research supports clinical supervision as being effective in reducing compassion fatigue and burnout, this study seems to suggest that the implementation and understanding of child life supervision needs to be reviewed and re-evaluated.

Experts in the field of work-related stressors state there are multiple reasons to consider, apart from supervision, that are key factors in causing or treating burnout and compassion fatigue. According to some, burnout is influenced as much by the individual as it is by the department and institution as a whole. Not only should one look at personal actions, but also look the departmental and institutional actions and values, and whether they fall in line with those of the professional.

continued on Focus page 4
If there is a major discrepancy between the individual and the department or institution, one should consider whether the present job location is a good fit because burn out is more likely to occur under such circumstances (Bartell, 2012).

In the present study, there was a higher risk for compassion fatigue among child life specialists than burn out. Although supervision helps to reduce compassion fatigue, experts in the field of trauma state that a primary way to reduce compassion fatigue is to restructure mindsets and beliefs in order to build resiliency. Resiliency is defined as the ability to grow stronger, not weaker, from traumatic experiences. It is suggested by leading researchers in the field of the National Child Traumatic Stress Network that a main reason why child life specialists are so susceptible to compassion fatigue is they do not use certain skills often enough that are vital to maintaining resiliency, such as optimism and mastery over clinical experiences.

Mastery is another skill that builds resiliency. Mastery involves learning to recognize which situations are out of a child life specialist's control. This naturally helps a child life specialist to better understand things that are worthy of her or his emotional, physical and psychological energy so that time is better spent and unrealistic expectations are avoided, thereby reducing compassion fatigue (Chemtab et al. 2011).

Future areas to explore regarding supervision may include the beliefs and perceptions of the roles and responsibilities in the supervisor-supervisee relationship. Experts in the field of supervision (Delano & Shah, 2011; 2009) state that, for supervision to be effective, there must be a clear understanding on the part of both the supervisor and supervisee regarding the reflective process, the definition of quality supervision, and the implementation of educational opportunities. Both the supervisor and the supervisee have the responsibility to maintain the quality of supervision, and both roles are equally important. Delano & Shah’s 2011 article, Games Played in the Supervisory Relationship, the Modern Version, demonstrates how the effectiveness of supervision drastically decreases when a supervisor or supervisee plays ‘games’ that reduce the quality of supervision.

Limitations of the present study include the Supervision Survey asking only questions regarding the frequency, location and perceived effectiveness of supervision and not addressing whether certain aspects of supervision are understood or being implemented. More so, the Supervision Survey has not been validated or used elsewhere. Other limitations include a lack of certain demographic information such as age, length of practice, full-time v. part-time, and other information that could have been useful for more informative data found in this study.

However, the findings of this study suggest that it is not the frequency of supervision being given that is causing it to be ineffective, but perhaps the quality and general understanding of what supervision should entail. Future research should examine the components of clinical supervision as well as the mindsets of both the supervisor and supervisee. Using the ProQOL (Stamm, 1995) to compare results with a revised supervision survey might help reveal components necessary for effective child life clinical supervision that reduces compassion fatigue and burnout. This study suggests that supervision is being consistently carried out within the institutions surveyed, which is a step in the right direction. As cited above, effective clinical supervision incorporates ongoing evaluation and review of the quality of supervision (Hawkins & Shoher 2000, in Rode, 2005). Child life departments should consider implementing opportunities for evaluation of their current supervision processes in order to learn what is effective and what is not effective in decreasing burn out and compassion fatigue while strengthening the professional’s growth in both clinical skills and self-care.

As stated in the beginning, symptoms of compassion fatigue and burnout are “a
**APPENDIX A**

**PROFESSIONAL QUALITY OF LIFE SCALE (ProQOL)**

**COMPASSION SATISFACTION AND COMPASSION FATIGUE (ProQOL) VERSION 5 (2009)**

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1 = Never  
2 = Rarely  
3 = Sometimes  
4 = Often  
5 = Very Often

1. I am happy.
2. I am preoccupied with more than one person I [help].
3. I get satisfaction from being able to [help] people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I [help].
7. I find it difficult to separate my personal life from my life as a [helper].
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
9. I think that I might have been affected by the traumatic stress of those I [help].
10. I feel trapped by my job as a [helper].
11. Because of my [helping], I have felt “on edge” about various things.
12. I like my work as a [helper].
13. I feel depressed because of the traumatic experiences of the people I [help].
14. I feel as though I am experiencing the trauma of someone I have [helped].
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a [helper].
20. I have happy thoughts and feelings about those I [help] and how I could help them.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
24. I am proud of what I can do to [help].
25. As a result of my [helping], I have intrusive, frightening thoughts.
26. I feel “bogged down” by the system.
27. I have thoughts that I am a “success” as a [helper].
28. I can’t recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

© B. Hudnall Stamm, 2009. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)/www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.
diagnosis waiting to happen” (Figley, 2002, p. 20, Skovholt, 2000). It is not a matter of resisting compassion fatigue and burnout, but rather acknowledging when they occur, assessing why they occur, and then acting in ways to overcome these stressors. Child life specialists and other healthcare workers should view symptoms of compassion fatigue and burnout as a continuum of learning experiences (Bartell, 2012). All professionals have a personal responsibility to address work-related issues that have the potential to decrease their professional effectiveness, which is a sign of a professional who is growing in both skill and understanding of all aspects within their practice (Skovholt, 2001). Supervision, if utilized correctly, could be one way to carry out this responsibility.

**References**


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Child Life Council is pleased to announce the release of the new Internship Supervisor's Manual and Supplement:

Intern Supervisor's Manual for Child Life Clinical Internship Programs

This manual, developed by the Internship Task Force, includes information and activities that will be useful for both experienced and new supervisors of child life clinical internship programs. Some of the content is in a workbook format, with activities designed for use alone or with colleagues. Other activities will help to improve planning skills, reflective practice, and evaluation, and direct communication with interns. The manual is structured so that it may be used as a whole or in separate parts as needed.

Internship Curriculum Supervisor's Supplement
(this PDF can also be found within the Supervisor’s Manual as appendix E)

The supervisor's notes for each module mirror the assignment section found in each of the Curriculum Modules and are intended to provide suggestions for the supervisor in her/his guidance of the intern's learning during the completion of each module. The Supervisor's Supplement was written for those in a direct supervisory role of a child life intern.

This is a CLC member benefit! Download your copy at:
http://www.childlife.org/StudentsInternsEducators/InternshipCoordinators/InternshipSupervisorsManual.cfm
30th Annual Conference Celebrated Three Decades of Professionalism, Community, and Dedication

A MONUMENTAL YEAR, A MONUMENTAL PROFESSION

Thanks to the efforts of the Conference Planning Committees, a dedicated group of volunteers, and the contributions of our 30th Anniversary sponsors, the 30th Annual Conference and Anniversary Celebration was a spectacular success! The child life specialists who joined us for the event in Washington, DC were treated to three days of quality networking and educational experiences.
Book Review: The Handbook of Child Life

Elizabeth Ayoub, CCLS, Helen DeVos Children's Hospital, and Ken Edwards, MS, CCLS, Illinois State University, Members, CLC Professional Resources Committee

The Handbook of Child Life (2009), compiled and edited by Richard Thompson, is one of the most useful tools available for the child life specialist or student. Written by child life specialists and experts across North America, this book contains practical information on topics spanning the profession.

Each of the 16 chapters of this work is authored by one or more writers; this makes for a total authorship of 31 professionals. This provides a wide variety of educational backgrounds and experiences, and also creates a wide range of different voices. The vast knowledge available in this single resource compensates for the variety of writing styles, and the stand-alone nature of the chapters benefits the reader looking for readily available answers.

Overall, the work is well-written and fairly concise. The book begins with the groundwork for child life: therapeutic relationships, play, family-centered care, and communication. Theories are described concisely and coherently and are supported by relevant research. The theories covered move beyond the developmental basics and include a variety of mid-level theoretical perspectives that expand the way we assess and engage with children and families, such as temperament, stress and coping, and ecological theory. Professional relationships and communication are explored as well, as they connect theory and use in daily practice.

There is a chapter on the global perspective of child life and this is a valuable addition, but perhaps some authorship representing the international child life community may have been beneficial. As a profession, child life is becoming more global and the children and families we work with certainly represent a wide range of diversity. The roles of child life, play, and hospitalization vary by culture and it is important to understand this in order to be able to advocate for child life practice and for the children and families with whom we work all over the world.

One of the biggest limitations of The Handbook of Child Life (2009) is one that we are likely all familiar with as child life specialists: a lack of current research. The chapters are well cited with many and varied resources, however, the majority of the resources cited date from the 1980s and 1990s. Expanding child life research is an area that is imperative at this time, and in fact, Thompson dedicates a whole chapter to this subject. Throughout that chapter, the authors encourage both clinical child life specialists, as well as academics, to work together to conduct and publish more research supporting child life practices. They identify the many difficulties in conducting accurate child life research but also offer practical suggestions. The exhortation from the authors stands, that “all professionals in the field need to be more resourceful in identifying resources and forming alliances to provide a support system for research endeavors” (p. 52).

It is important to remember that The Handbook of Child Life (2009) contains chapters on many topics which provide overviews of complex subjects. These chapters should not be the sole reference for a topic but a jumping off point. The chapters on family-centered care and assessment and documentation are good examples. Both are well written introductions to important topics. While fewer case studies are used in these chapters, sample forms are supplied. The chapter on paradigms of play was well organized, covering both classic theories and newer ideas. This chapter is beneficial in defining and relating the value of play to hospitalization. It may be beneficial to a beginning child life specialist or student to additionally review the information in Psychosocial Care of Children in Hospitals: A Clinical Practice Guide (1990) for specific descriptions of “Health Care Play.” These would appear to be highly complementary resources.

In addition to the guidance and recommendations for working with patients and families, the book includes chapters on integrating child life practices into the hospital system. Regularly $55.95, CLC members can purchase this book for a reduced price of $45.00! Visit the Child Life Council online bookstore at www.childlife.org; after you sign in, click on the Bookstore link.

Point of Care Scholar

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effectiveness of music therapy in hospitalized children. Work that is started in the POC Scholar year often serves as a springboard for evidence-based change and continued work in a particular area.

I am still in the midst of my POC Scholar year, tackling the clinical issue of the effective use of praise or reward for children undergoing stressful medical encounters. My personal experience with the POC Scholar program has been a very positive one, and I have been grateful for the opportunity and support from my department and the hospital to be a part of this program. Other institutions may have similar programs to help interested clinicians get started in EBP, and our perspective as child life staff is a unique one in identifying clinical issues. As clinicians, we all have questions in our clinical areas where we might ask ourselves, “Why do we do it this way?” As we progress in health care, it is important not to accept the answer of “well, that’s the way we’ve always done it.” By asking clinical questions and looking to the evidence for answers, we can ultimately provide patients and families with the best clinical care and the outcomes that they deserve.

REFERENCES

P Is for Parental Presence

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As a profession, we recognize the importance of the family in relation to the child’s method of learning and coping; we learn very early on that for pediatric patients, separation from parents/caregivers can quickly magnify an already difficult situation. We are obligated as child life professionals to promote patient and family-centered care, recognizing “the vital role that families play in ensuring the health and well-being of infants, children, adolescents, and family members of all ages,” acknowledging the child as part of a larger family unit. We are confident that this approach “leads to better health outcomes and wiser allocation of resources, and greater patient and family satisfaction” (Institute for Patient and Family Centered Care, 2012). We also strive to promote the American Academy of Pediatrics Statement on Child Life (2000), which asserts: “because the presence of family members has an important positive effect on a child’s adjustment to the health care experience, pediatric health care teams encourage family involvement in patient care” (p. 1157). On a daily basis, from the treatment room to the playroom, we work not only with pediatric patients but also their family units, involving them in interventions that target coping, educating, and healing. It is our hope to have anesthesia and the entire surgery team as part of this continuum as we safely expand care and serve children and their families.

Although the details may differ among facilities, PPI generally allows one parent, if they wish, to remain with their child while he or she initially receives anesthesia. The clear goal of PPI is to lessen the anxiety associated with separation from a parent/caregiver prior to anesthesia induction and to provide greater emotional security and less anxiety for the child during induction. A successful PPI program is a forward thinking and exciting addition to our care and requires collaboration among all the professionals involved.

In addition to helping to create a better experience for children and their families, it is our hope that PPI and our service might shorten time in the operating room and improve anesthesia outcomes by making the experience less traumatic. Christopher Hunt, MD, pediatric anesthesiologist, states, “The literature is clear on the fact that a traumatic anesthetic induction can have a negative impact on the anesthetic management of a case. Our interaction with the child life professionals has shown that PPI is a valuable tool at our disposal.” Always taking into account the safety of the child during induction, paired with a specific process and thoughtful assessment of the members involved, child life specialists can make PPI a wider used practice, one in which supportive research is bound to follow. This improved efficiency benefits everyone involved in the care of children in pediatric settings.

PPI often relies heavily on the child life specialist to prepare the patient and family member, and facilitate communication and coordination among medical staff. The process of a successful PPI experience for all involved begins with assessment. Assessment of the child goes without saying, but assessing the parent, their anxiety, their involvement with the child, and the overall process of the PPI team are necessary as well. Knowing that the anxiety experienced by parents/caregivers can be transmitted to the child receiving treatment, the willingness and desire to participate as well as being receptive to direction and education can improve the process and its outcome. The formality of the operating room and the high level of intensity and careful practice related to anesthesia management should not be forgotten so a process, flow and awareness of each team member’s duties during induction are a necessity.

As professionals, we must strive to make value-based services, such as PPI, an available, safe and well-organized option for those we serve.

References

Institute for Patient and Family Centered Care (2010). www.ipfccc.org
President’s Perspective
continued from page 2

attend the annual American Society of Association Executives (ASAE) conference, where they learn association best practices and leadership strategies. To ensure a smooth transition of presidential duties, the President-Elect joins in weekly conference calls between the CLC President and Executive Director to execute decisions and to review the progress of all task forces, committees and CLC office initiatives. The Past President also remains on these calls to provide support for the first three months after the new President takes office.

CLC’s ability to keep abreast of health care, economic and social changes will ensure its sustainability. As mentioned, continually modifying our methodologies and practices will allow CLC to remain aligned with current trends, and will help to ensure our continued growth and success. The 2012-2014 Strategic Plan was created expressly to meet and overcome the challenges ahead for the child life profession and this organization.

The Child Life Council will focus on the following goals:
1. Credibility: Promote the credibility of the child life profession.
2. Member Services: Provide timely, innovative, and high quality programs, products, services, and networking opportunities to its members.
3. Influence: Promote the presence and expansion of child life services in all health care and related settings serving infants, children, and youth.
4. Resources: Attain the financial and human resources necessary to carry out the strategic plan.

What might child life look like in 2020 because of this vision?

Professional practice will be standardized to provide consistent quality psychosocial care and secure child life specialists’ credibility as experts in this area and as valued members of a multidisciplinary team. Students will be trained in accredited academic and clinical settings, and with their advanced degrees, they will enter the profession with more confidence and expertise. With the addition of a CLC Development officer, the organization will have established funding for research, including a study related to the economic value of child life services. Consequently, we hope to make a stronger case for securing child life positions in health care and related settings. Additional financial support from grants and/or donors will make it possible for CLC to hold its first International Summit to explore and share psychosocial practices globally, as well as explore the possibility of commencing a CLC Leadership Institute to promote leadership development at the highest level.

Advances in technology will allow CLC to increase public awareness of and support for child life, as well as provide additional services and networking opportunities to the membership.

In conclusion, I want to say that it was my privilege and honor to serve you, our CLC membership, during this exciting time in the Child Life Council’s history. I confidently turned the gavel over to Diane Hart, knowing that she will continue the momentum forward to reach our strategic and professional goals.

Visit the Child Life Marketplace

If you haven’t had the opportunity to visit the Child Life Marketplace, you could be missing out! The directory provides convenient access to contact information from a growing number of organizations that work with the child life community. Some vendors offer discounts and special offers exclusive to CLC members. If you have worked with one of the businesses or nonprofit organizations listed in the Marketplace, consider sharing your experiences with your colleagues by rating and commenting on a listing. Be sure to visit regularly to check out what’s new on the site! Visit the Child Life Marketplace at http://marketplace.childlife.org/

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Gail Klayman

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Demonstrates the ability to work collaboratively with other health care team disciplines in the delivery of patient care which results in positive outcomes for patients.

Gail is wonderful at collaborating with the health care team. She always strives to get input from key players and multiple disciplines when working with a patient or spearheading a change. For example, she started a medical task force including physicians, nurses, and parents to create a best practice statement for CCHMC on what type of anti-anxiety medication was the most beneficial for patients with developmental disabilities. In another instance, after observing the particular difficulty that patients with autism were having in waiting rooms, Gail helped to develop and train the CCHMC registration staff on strategies to make that waiting and transitioning time less stressful.

Models exemplary practice of child life through critical thinking, inquiry, evaluation, and a commitment to continuous improvement.

Gail is constantly striving to improve outcomes and experience of care for patients and families. Most recently, Gail collaborated with her colleague, Jennifer Staab, MS, CCLS, on the development of the Psychosocial Risk Assessment in Pediatrics (PRAP) tool, which is designed to evaluate a patient's vulnerability and identify priority patients. In another recent example, Gail participated in a quality improvement study in which patient care attendants were provided with training on how to work with patients with developmental disabilities, which led to a significant reduction in staff injuries from patients who are aggressive. She also collaborated on the development of an evidence-based practice statement on the use of anxiolytic medication with patients with developmental and behavioral challenges.

Demonstrates competence and an ability to provide effective interventions in a variety of situations.

Gail has a strong foundation in child life and is able to adapt her knowledge to meet any support needed. Years ago, Gail was the first child life specialist to provide programming in both the NICU and Starshine Hospice. She helped develop a bereavement protocol for supporting families with the death of their child. While Gail worked in the Division of Developmental and Behavioral Pediatrics, she helped develop interventions to help patients wait calmly in the waiting room, cooperate with vitals, and cope with the developmental pediatrician's exam. She also created a preparation tool for families known at CCHMC as “homework,” which outlines how families can help prepare their child by practicing the different steps of the procedure at home prior to an appointment.

“While she is very passionate about supporting the patients and families she works with, she never loses sight of appropriate professional boundaries. The values I see Gail strive for everyday of her professional life include acceptance, advocacy, compassion, being proactive, and individualization. These values influence every action she makes and come across in all the amazing work she does with the patients and families here at the hospital.”

Models child life practice and team behaviors that acknowledge and respect the diversity of patients/families and members of the health care team.

Gail’s professional goal for the past five years has been to help combat the healthcare disparity experienced by patients with developmental and behavioral challenges. When she first started working in the Division of Developmental and Behavioral Pediatrics, she saw that many families stopped coming to the hospital for preventative care because their experiences had been so negative and traumatic. She assessed the need. If she realized that the hardest thing was transitioning the child out of the car into the clinic setting, Gail would meet the child at the car with items of interest and sometimes visual supports. When designing our new developmental pediatric clinic, Gail participated in the meetings with the design team and families to help ensure the new building would meet the unique needs of this patient population.

Demonstrates strong professionalism and values-driven interactions that include clear, supportive, boundaries-sensitive, and professional relationships with patients and families.

Gail is caring, empathetic, and professional when interacting with patients, families, and health care staff. While she is very passionate about supporting the patients and families she works with, she never loses sight of appropriate professional boundaries. The values I see Gail strive for everyday of her professional life include acceptance, advocacy, compassion, being proactive, and individualization. These values influence every action she makes and come across in all the amazing work she does with the patients and families here at the hospital.

Exercises sensitivity to the individual circumstances of patients/families circumstances and provides supporting and nurturing care.

Knowing that it can be very difficult for patients with developmental and behavioral challenges to understand and cope with invasive health care appointments, Gail created a program called ACT (Adaptive Care Team), which currently has two staff members. The goal of ACT is to facilitate parent/staff collaboration to prepare and plan safe and sensitive support, in order to alleviate potential trauma and mistrust of health care professionals. Gail’s interventions are tailored to each child and family to build on their strengths. She acknowledges the family as the expert on their child and brilliantly collaborates with them to come up with an adaptive care plan for their child.

Embraces and models the core concepts of family-centered care, including information sharing, supporting patient/family participation, collaboration and involvement in their care.
Gail was one of the early child life specialists to begin pioneering child life services at CCHMC. With her support and advocacy, families were given 24-hour visitation rights in the early 1970s. She was also an instrumental figure in the family-centered care movement at CCHMC in the 1980s. At that time, Gail helped advocate for families to be allowed to be present during report at rounds and during procedures. Gail also encourages health care staff to ask the parents for helpful tips on how to best interact with and support their child before beginning an exam or procedure. As a result, parents feel more empowered to speak up and advocate for their child before procedures. Gail also encourages health care staff to ask the parents for helpful tips on how to best interact with and support their child before
beginning an exam or procedure. As a result, parents feel more empowered to speak up and advocate for their child before

The development and incorporation of evidence-based practice.

In the development of the PRAP, Gail worked tirelessly on ensuring the tool is evidence-based and clinically effective; she was involved in coordinating the research and working as a field investigator in recruiting and collecting data for 200 study participants. Gail has also been working with the perioperative staff at CCHMC on developing best practice strategies for patients with developmental disabilities and behavioral challenges coming for surgery. Gail has presented on these and other activities at Child Life Council conferences, as well as other health care conferences, and Pediatric Grand Rounds at CCHMC.

Mentors new child life specialists and students in developing child life competencies and supporting the effective transition to professional practice.

Gail has mentored and supported many students in developing child life competencies over the years. She is always thorough and patient, allowing the student to build confidence and skills needed to be a successful child life specialist. According to one child life specialist who benefitted from her influence, “More than any other aspect of my child life training, Gail’s mentorship helped shape me to be the child life specialist I am today.” In addition to mentoring child life specialists on an individual basis, Gail provides an in-service on working with patients with developmental and behavioral challenges to all new child life employees.

Actively participates as a member of the Child Life Council.

Gail has been a member of the Child Life Council since 1986, and prior to that she was involved in the Association for the Care of Children’s Health (ACCH). Gail reads Child Life Focus religiously, and incorporates CLC’s Evidence-Based Practice statements into her education, presentations, and own practice.

The Child Life Council congratulates Gail on her selection as the recipient of the 2012 Mary Barkey Clinical Excellence Award! If you are interested in submitting the name of a colleague for the 2013 award, the call for nominations was recently issued online, and initial nominations will be accepted through August 15, 2012. Complete nomination packets with supporting materials are due September 14, 2012.

Upcoming CLC Webinars

Wednesday, September 12, 2012
Psychological Approaches for Procedural Pain Management in Children
Presented by:
Christine Chambers, PhD, RPsych

Wednesday, October 3, 2012
Implementing Evidence-Based Practice into Clinical Practice
Presented by:
Kate Shamszad, MS, CCLS
Jennifer Staab, MS, CCLS

Tuesday, October 16, 2012
History of Child Life - Free for Members!
Presented by:
Civita Brown, MS, CCLS
Lois Pearson, MEd, CCLS

Wednesday, November 7, 2012
Four Key Fundamentals in Medical Play
Presented by:
Mary Faith Roell, MS, CCLS
Katherine Nees, MSHS, CCLS
CLC Calendar

**SEPTEMBER**
28-30  CLC 31st Annual Conference Planning Meeting

**OCTOBER**
15  Deadline for Bulletin and Focus articles for Winter 2012 issue
15  Deadline for written requests to withdraw from November Administration of the Child Life Professional Certification Exam
31  Late Deadline to recertify with Professional Development Hours (late fee and additional paperwork required)

**NOVEMBER**
1-15  Child Life Professional Certification Exam Administration Testing Window
8-10  CLC Board of Directors Meeting

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